Minnesota WIC Program

Medical Formula Documentation

Infants Less Than Six Months

ID #: _____

Return completed form to the WIC clinic or have your patient return the form to the WIC clinic.

Fax #: 952-891-7565 Attention: - Phone #: -

or Mail to: Dakota County Public Health - WIC 14955 Galaxie Ave, Apple Valley, MN 55124

Completion of this form is federally required to ensure that the patient under your care has a medical condition / diagnosis that requires the use of medical formula.

A. Patient Information: *(Complete all)*

Patient's Name *(First & Last)*:	DOB:
Parent / Caregiver's Name *(First & Last)*:	Phone #:

B. Health Care Provider with prescriptive authority: *(Complete all sections)*

Formula Requested:
Medical Diagnosis:
(Justifies the prescription of above formula) Prescribed amount per day: ☐ Maximum allowable or oz. per day Tube Feeding: ☐ Yes ☐ No
Instructions for preparation: ☐ Standard dilution ☐ Other:
Number of months needed: ☐ 1 month ☐ 3 months ☐ 6 months ☐ until 1 year corrected age ☐ Other:

C. Health Care Provider Information: *(Complete all)*

SIGNATURE (Health Care Provider):	Date:
Printed Name (Health Care Provider with prescriptive authority):	☐ MD ☐ NP ☐ PA ☐ CNM ☐ DO
Medical Office/Clinic:	
Address:	
Phone #:	Fax #: